20.

A REPORT OF FOUR LUETIC CASES UNASSOCIATED WITH OBSERVABLE SECONDARY MANIFESTATIONS.

BY

GEORGE M. MAC KEE, M.D.
NEW YORK

Reprinted from the MEDICAL RECORD
April 6, 1907

WILLIAM WOOD & COMPANY
NEW YORK

A REPORT OF FOUR LUETIC CASES UNASSOCIATED WITH OBSERVABLE SECONDARY MANIFESTATIONS.

By GEORGE M. MAC KEE, M.D.,

NEW YORK.

INSTRUCTOR OF DERMATOLOGY AT THE UNIVERSITY AND BELLEVUE HOSPITAL MEDICAL COLLEGE.

The following histories are from cases treated in private practice, the patients having sufficient intelligence to appreciate the character of the disease in question as well as the necessity for a positive diagnosis. They aided me in every possible way in my observations, and I never had any reason to doubt their veracity.

Case I.—Mr. A., twenty-two years of age, single, employed as a clerk in a large wholesale house. First came under observation September, 1902, presenting a small nonindurated ulcer lying in the sulcus on left side of frenum. It was impossible to estimate the incubation period because of frequent intercourse. The ulcer had been present three days and no treatment of any kind had been applied previous to the first visit. Although a diagnosis of chancroidal or herpetic ulceration was made, the possibility of syphilitic infection was explained, expectant treatment advised, and the patient placed under observation, making three visits to the office each week for a period of three months. The ulcer, which became slightly indurated, persisted for three weeks when it healed without leaving a cicatrix, although the induration remained for a week or more. He

also had a mild bilateral inguinal adenitis which entirely disappeared four weeks after the ulcer healed. Six weeks after the first consultation, enlargement of the axillary and cervical glands was observed, but when the patient stated that he was subject to mild attacks of adenitis, no importance was attached to the discovery. Throughout the entire three months he remained in excellent general health, had no fever, no eruption, alopecia, throat or mouth symptoms, nor, in fact, any manifestation of secondary syphilis, and was therefore told that although the danger could possibly extend over another month he could discontinue his office visits.

On May 10, 1906, he again consulted me regarding a livid red infiltrated nonpruritic circinate patch covered with a few tenacious epidermic flakes on the palm of the left hand at the base of the thumb. The chain of glands along the radial side of the flexor surface of the forearm were the seat of gummatous degeneration, and the overlying epidermis was stained a deep copper color. The pharyngofaucial and nasal mucous membranes were extensively infiltrated. The patient also complained of severe headaches and rheumatic pains. This state of affairs had existed for about three months, the symptoms gradually increasing in severity. Six grains of the salicylate of mercury were given in divided doses by means of deep muscular injections, one grain being administered each week. As a result of this treatment the lesions promptly disappeared. Although having been advised to report again in two weeks for further treatment he has thus far failed to follow instructions. This patient absolutely denies any primary, secondary, or tertiary manifestations excepting those above mentioned. In this case one must consider the possibility of the secondary eruption occurring after the ninety-day

limit and being so mild as to escape his attention in spite of the fact that he had been warned of its possible occurrence. It is also possible that primary and secondary lesions existed before or after my first series of observations, and either escaped his attention or were wrongly diagnosed. Finally he may have for some unknown reason given false answers to questions relative to his history.

Case II.—Mr. H.,* twenty-two years of age, waiter by occupation, unmarried and presenting a history of several attacks of herpes progenitalis. On October 26, 1903, three days after sexual intercourse, he developed a group of herpetiform vesicles situated in the sulcus one-half inch from the frenum, which soon ulcerated and uniting developed a discharging ulcer about one-half inch in diameter involving the frenum and glans. Several small ulcers formed on the glans and mucous surface of the prepuce. Cleanliness was difficult in this case because of the excessive purulent discharge and a somewhat redundant foreskin. Beginning on December 23, the lesions were sparked for five minutes every second day with the current derived from the secondary coil of the Piffard hyperstatic transformer, a static machine being employed as the generator. After seventeen days of such treatment the sores had entirely healed. On November 24, 1906, he presented a scaly papular syphilide on the palmar surface of the left hand, a circinate papular syphilide on the dorsal surface of both hands, and two circinate papular slightly eroded patches on the glans penis. On the left shin there was a large hypertrophied papule covered with psoriatic scales.

*The history of this patient was given in an article entitled "The Treatment of Chancroidal, Herpetic, and Varicose Ulcerations by the High-Frequency Spark." Published in the *Journal of Cutaneous Diseases,* December, 1905.

On the outer aspect of the right foreleg there were several infiltrated patches of the papulosquamous type. These lesions had existed about six or eight weeks, but responded at once to mixed treatment. At the present writing nothing remains but the characteristic pigmentation. This patient positively declares that he never had any cutaneous lesions with which I am not acquainted, excepting an occasional attack of herpes, which were never severe enough to merit attention. He was married in the fall of 1904, and so far as can be determined his wife has never developed any signs of the disease. Inasmuch as the patient was only under personal observation for a period of seventeen days, coupled with the fact that no direct attention was given to the possibility of syphilitic infection, mild secondary manifestations could readily have been overlooked.

Case III.—Mrs. W., twenty years of age and married about one year. The first consultation was on August 8, 1904, at which time she presented a large ulcer on the right labium majora with a smaller one on the left side. Both labia were edematous and indurated. The ulcers had been present about two or three weeks. Both chains of inguinal glands were involved, but there was no adenitis elsewhere at the time, nor did any develop subsequently. A careful inspection of the entire body failed to demonstrate any other lesions of the skin or mucous membranes, excepting a very slight sore throat which only lasted three days. She was quite certain that no other eruption had existed prior to her first visit. The possible nature of the disease was explained to both the patient and her husband, who positively denied any syphilitic history, and they promised to note any suspicious symptoms. The ulcers had entirely healed by August 22, and up to September 15 not a single secondary manifestation had been

observed. On this date, however, the patient gave birth to a male child of about seven and one-half or eight months' gestation. The child, which only lived a few minutes, was poorly nourished and although not having definite lesions, presented the general features of a syphilitic infant. The placenta also showed signs of degeneration. One year later another premature labor occurred at about the seventh month. This time, according to the statement of the girl's brother, the infant was covered with sores, poorly nourished and lived but a few hours. In the interval of time elapsing between the two confinements there had been no other manifestations of the disease nor had antisyphilitic treatment been administered. In September, 1906, an apparently healthy, full term child was born. The husband failed to contract the disease and they both consider my fears groundless, but it will be of no little interest to watch for future developments in this interesting family. The fact that the husband failed to become infected naturally suggests the possible source of the patient's inoculation. In this connection I recall a young woman who was married in June, 1902, and who developed a genital chancre in July of the same year, which was followed in six weeks by secondary symptoms. Her husband positively denied having had the disease, nor could I discover any manifestations of the same upon his body. Although failing to take any special prophylactic measures, he has to this time failed to contract the disease.

Case IV.—Mr. J., twenty-seven years of age, single, employed as a bookkeeper in a publishing house. This patient developed a severe attack of gonorrhea on January 17, 1903, nine days after cohabitation. Thirteen days later he developed a slightly indurated penile ulcer, which persisted for three

months, leaving a cicatrix after healing. His gonorrhea, which was complicated with prostatic involvement, necessitated daily treatments for a period of four months, during which time I made daily examinations of his entire body for the secondary eruption which was certainly expected. The inguinal glands were involved, but at no time was any general adenitis, alopecia, sore throat, nor any manifestations of the suspected disease observed. Yet this patient on March 12, 1906, presented unmistakable signs of neglected syphilis. There was an ulcerating lesion of the left shin, accompanied with characteristic pigmentary changes, which had begun, according to the patient's observation, some weeks previously as a bruise, the result of an injury. The ulcer failed to improve under local applications, but promptly responded to mixed treatment. He states positively that he never had cutaneous lesions other than those recorded above.

The other histories may be defective, but surely if this patient had secondary symptoms they must indeed have been slight. Whenever a patient consults me regarding a possible primary lesion of syphilis I have always depended upon the development of the secondaries for a positive diagnosis and always supposed myself safe in so doing. I can distinctly recall many cases of young men having suspicious sores several years ago who subsequently failed to develop secondaries and who were told they need not worry longer.

In all probability the diagnosis of chancroid or ulcerated herpes in these cases was correct. For their sake at least it is to be hoped so. I specifically recall one young gentleman who contracted a sore having an incubation period of two weeks from a young woman who at the time was under treatment for secondary syphilis. This patient was

placed under strict observation. The sore required several weeks to heal. At one time there appeared to be a slight macular eruption on the thorax under the arms, at the same time he became anemic and developed acne pustules upon the back. A consultation was held with an eminent syphilographer, who decided against specific infection. Under tonic treatment the patient soon regained his usual good health and has retained the same to the present writing.

Now the following question naturally arises: Upon what features can a safe diagnosis of early syphilis be made, and when should constitutional treatment be instituted? This question has been discussed in text books, in papers and at society meetings, yet the opinion of the medical profession remains divided. Fournier,[1] who is of the same opinion as Ricord,[2] starts constitutional treatment as soon as the primary lesion presents the features of the syphilitic chancre. By so doing he believes an ultimate cure is more likely to be effected. At the same time he advises extreme caution and whenever the slightest doubt exists he awaits the appearance of the secondaries. Van Buren and Keyes,[3] Lydston,[4] Wild,[5], and in fact the majority of writers concur in this opinion. Dumesnil,[6] Taylor,[7] and others, on the other hand, owing to the fact that nonsyphilitic sores may simulate the typical chancre and *vice versa*, consider the difficulties of a diagnosis in this stage so great as to make the giving of mercury unjustifiable, no matter how plainly marked the case may be. The only advantage in employing constitutional treatment in the primary stage is in the possible prevention of severe secondary symptoms and to attack the disease before it becomes deeply seated. Now as a matter of fact the secondaries will appear as a

rule whether mercury has been given or not. The fact that they sometimes do not occur when mercury has been given is certainly a poor criterion inasmuch as they may fail to appear in cases which have not been so treated. Regarding the effect of early treatment upon the remote course of the disease there is no good reason to believe that this method has any advantage, at any rate the evidence is as strong one way as it is the other. If energetic treatment be given immediately upon the appearance of the secondaries these symptoms will usually be very mild indeed. We must also consider the moral effect of the secondary manifestations. If during the primary period of the disease the patient receives proper instruction and is told that the diagnosis rests upon the appearance of secondary symptoms, he will naturally be impressed with the nature of the disease when these symptoms develop. On the other hand, if early treatment has been given and the secondaries fail to follow, the patient will, after a few months, unless he has unlimited confidence in his physician, doubt the diagnosis and become indifferent to the treatment. It not infrequently happens that this feeling of doubt is also shared by the physician.

A positive diagnosis can of course be made when the secondaries develop and appropriate treatment immediately begun. But when the secondaries do not follow a suspicious sore, can one without awaiting further evidence positively say that syphilis does not exist? All authors with whose writings I am familiar, although admitting that the secondary symptoms may be so mild as to be overlooked or ignored by the patient, believe they always do occur and can always be demonstrated by careful observation. It is no uncommon occurrence, especially in dispensary practice, to have patients present ter-

tiary lesions and have no knowledge of primary or secondary symptoms. This happens most frequently in women, who often have a uterine chancre and who very often overlook the subsequent inguinal adenitis and superficial eruptions. Again the eruptions of the secondary period may be modified by being associated with other skin affections, and the true character of the disease not recognized.

The first three cases mentioned in this paper may or may not have had secondary symptoms. The fourth case did not develop them unless they appeared after one hundred and twenty days. It is of course possible that this patient may have had a neglected infection prior to my observations. Considering that the case is truly represented, it is probable that such cases are of rare occurrence, and as a rule it is safe to base a diagnosis upon the appearance or nonappearance of the secondary manifestations. It should, however, be borne in mind that these symptoms may not only be mild but entirely absent. In this connection the organism of Shaudinn and Hoffmann should receive consideration. Although the majority of investigators feel certain that this organism is the etiological factor of syphilis, there are many dissenters, and until absolute proof is forthcoming one may not be entirely exempt from criticism if the diagnosis be based upon the finding of the *Spirochæta pallida* alone. So far as I am aware, all patients having a sore in which these organisms were found have later developed secondaries, while on the other hand cases in which the pallida could not be demonstrated failed to develop secondary manifestations. I[8] reported several such cases last spring. W. B. Trimble,[9] at the ninety-seventh regular meeting of the New York Society of Dermatology and Genitourinary Diseases, reported the case of a man thirty-four

years of age, presenting a lesion of the upper lip having all the features of an initial sclerosis. This patient was seen by several eminent dermatologists, who unhesitatingly made a diagnosis of chancre. A careful search for the *Spirochæta pallida* resulted negatively. This patient was under observation for four or five months, at which time the ulcer, although reduced in size, was still present, but secondary lesions had failed to develop. It is safe to state that in all probability there would be considerable difference of opinion regarding the advisability of starting mecurial treatment in this case. Dr. Trimble preferred to keep this patient under prolonged observation rather than make a positive diagnosis upon the evidence as presented. Many physicians will agree, while others will disagree with this method. I am still in accord with such procedure in spite of experience with cases as recorded in the beginning of this article. Regarding the association of the *Spirochæta pallida* with the primary and secondary lesions of syphilis, it must be remembered that they often can not be found after the process of repair sets in. They are also difficult to demonstrate upon the surface of such lesions. The search should therefore be made as early as possible and in every case it is advisable to obtain a specimen after a fairly deep curettage. In doubtful cases the chancre may be excised and microscopical sections studied. The diagnostic serum devised by Wassermann, Neisser and Bruck[10] may be employed if the necessary material is at hand.

Conclusion.—The physician must recognize and assume the responsibility of a positive diagnosis of syphilis before advising the recognized course of constitutional treatment. He may consider the features of a given case sufficient to make a diagnosis in the primary period, but the establishment of a

diagnosis in this period is attended with considerable difficulty and inasmuch as the early use of mercury may modify the secondary symptoms to such an extent as to produce an hiatus in the patient's history, one certainly assumes a tremendous responsibility by this method. Although one can not absolutely depend upon the development of secondary symptoms in every case, it is undoubtedly a very rare occurrence for them to be overlooked by a physician who expects to see them appear. It would seem preferable, therefore, to accept this slight chance of ignoring a case rather than risk the possibility of condemning many, or even one innocent patient, to a life of mental misery and unnecessarily giving him several years of antisyphilitic treatment. A careful search for the *Spirochæta pallida* should be made in the primary and secondary lesions of every case, for if they are demonstrated one will add considerable strength to the diagnosis. The time is probably not far distant when a diagnosis of chancre can be based upon a diagnostic serum or by the microscopical examination of a smear preparation and the constitutional treatment at once instituted. It is not beyond reasonable expectation to anticipate the development of an antiluetic serum, doing away with the time-honored mercury.

REFERENCES.

1. Fournier: Prophylaxis and Treatment of Syphilis.
2. Ricord: Leçons sur le Chancre.
3. Van Buren and Keyes, Genitourinary Diseases, with Syphilis.
4. Lydston: Genitourinary, Venereal, and Sexual Diseases.
5. Wild: *British Journal of Dermatology,* May, 1906.
6. Dumesnil: *St. Louis Medical and Surgical Journal,* August, 1883.
7. Taylor: Genitourinary and Venereal Diseases.

8. MacKee: *American Journal of Dermatology,* St. Louis, Vol. 10, No. 4.
9. Trimble: *Journal of Cutaneous Diseases,* October, 1906.
10. Wassermann, Neisser, and Bruck: *Deutsche medizinische Wochenschrift,* May 10, 1906.

616 Madison Avenue